WASHINGTON DEPARTMENT OF FISH AND WILDLIFE

HUNTER / FISHER VETERANS REDUCED FEE APPLICATION

Mail to: WDFW, Licensing Division, PO Box 43154, Olympia, WA 98504

Fax to: (360) 902-2466

Please Print Clearly

APPLICANT INFORMATION REQUIRED

LAST NAME	FIRST NAME	MIDDLE	SUFFIX JR / SR

MAILING ADDRESS	PHYSICAL ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

SEX M / F	HEIGHT FT. IN.	WEIGHT	DOB	EYE COLOR	SSN

WILD ID	EMAIL	PHONE

Would you like to receive your reduced fee conformation using email? ☐ **YES** ☐ **NO**

Email Address:

COMPLETE FOR REDUCED FEE HUNTING AND/OR FISHING LICENSES

Both selections are automatic for this application : ☐ **Fishing** ☐ **Hunting**

This is for reduced fees only. This does not provide access to assistance cards, programs or facilities.
You must fill out the hunter/fisher disability application to receive Disability Status.

☐ **Resident Veteran:** with at least 30% service connected disability as verified by VA letter (RCW 77.32.480)

☐ **Resident Veteran: 65 years of age or older:** with a service connected disability as verified by VA letter (RCW77.32.480)

☐ **Non - resident Veteran:** with at least 30% service connected disability as verified by VA letter (RCW 77.32.480)

☐ **Non - resident Veteran: 65 years of age or older:** with a service connected disability as verified by VA letter (RCW77.32.480)

Veterans must include with this application a copy of their one page VA Percentage Rating letter showing name and disability rating clearly. Please do not send a copy of the multi-page medical determination report your physician sends to the VA Case Manager for adjustments. Letters can be obtain by logging into your premium account at www.ebenefits.va.gov and downloading the percentage rating letter. If internet access is unavailable, you may call the VA hotline at: (800) 827-1000 and request the one page percentage rating letter.

Applicant must sign this application below to be eligible for reduced fees

I hereby certify under penalty of perjury under the laws of the state of Washington that the foregoing information is true and correct.

X _____

Applicant's Signature *Date*

WDFW USE ONLY

Approved By:	Date:

WASHINGTON DEPARTMENT OF FISH AND WILDLIFE

HUNTER / FISHER REDUCED FEE APPLICATION

Mail to: WDFW, Licensing Division, PO Box 43154, Olympia, WA 98504

Fax to: (360) 902-2466

Please Print Clearly

APPLICANT INFORMATION REQUIRED

LAST NAME	FIRST NAME	MIDDLE	SUFFIX JR / SR

MAILING ADDRESS	PHYSICAL ADDRESS

CITY	STATE	ZIP	CITY	STATE	ZIP

SEX M / F	HEIGHT FT. IN.	WEIGHT	DOB	EYE COLOR	SSN

WILD ID	EMAIL	PHONE

COMPLETE FOR REDUCED FEE HUNTING AND/OR FISHING LICENSES

Both selections are automatic for this application : ☐ **Fishing** ☐ **Hunting**

This is for other reduced fees only. This does not provide access to assistance cards, programs or facilities. You must fill out the hunter/fisher disability application to receive Disability Status.

_____ **Resident who permanently use a wheelchair:** as certified by the physician's signature below (RCW 77.32.480)
MD Signature

_____ **Resident who is Blind or Visually Impaired:** central visual acuity does not exceed 20/200 in the better eye with corrective lenses or visual field is not greater than 20 degrees per physician's signature (RCW 77.32.480)
MD Signature

_____ **Resident with a Developmental Disability:** certified by DSHS Authority or Physician's certification (RCW 71A.10.020)
MD Signature

*The cognitive intellectual developmental disability such as cerebral palsy, down syndrome, epilepsy, autism, or another neurological condition of an individual found by the secretary to be closely related to an intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities, **which originates before the individual attains age eighteen**, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual. DSHS Authority must enclose a letter of certification on DSHS letterhead.*

***NOT included:** PTSD, Bi-polar, ADD, ADHD, Anxiety, Depression, Parkinson's, Multiple Sclerosis.*

Signature certification of permanent disability below.

I am a licensed physician for the above named person, and by my signature do certify under penalty of perjury of the laws of the State of Washington, this said applicant meets the above criteria having a permanent disability as I have indicated.

X _____ *Licensed Physician's Signature* *ARNP or PA Signature not accepted* *Date*

Physician's Name _____ Title _____
(Please print clearly)

Address _____ Zip _____

Telephone Number: ( ) _____ Medical License Number: _____
Mandatory

I hereby certify under penalty of perjury under the laws of the state of Washington that the foregoing information is true and correct.

X _____
Applicant's Signature *Date*

WDFW USE ONLY

Approved By:	Date: